Underneath the opioid crisis: The forgotten patients in pain

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Abstract

The opioid crisis has captured significant media attention in British Columbia. There is also an ongoing pain crisis, however, with one in five Canadians living with chronic pain. A fundamental reason for our reliance on opioids is a lack of effective and accessible alternative pain management therapies for patients with chronic non–cancer pain. We need to provide improved, multidisciplinary pain management, and ensure our efforts to curb opioid over–prescribing do not harm patients with pain. This will require us to improve access to non–pharmaceutical therapies, expand physician pain education, and conduct research to develop new therapies.

The opioid crisis is a major public health issue in British Columbia and has deservedly captured significant media attention. What has received less attention, however, are the people struggling with chronic non–cancer pain. Some patients with chronic pain rely on long–term opioid therapy and are now at risk of being denied pain relief due to the regulatory response to the opioid crisis. At its core, this situation is indicative of a lack of alternative pain management options. Alternatives to opioids are poor due to a shortage of therapies with proven efficacy and limited access to available resources. It is important that we do not allow patients with pain to fall between the cracks and instead strive to provide improved, multidisciplinary pain management for all patients.

Chronic pain is often defined as ongoing pain lasting over six months or, alternatively, as any pain that persists beyond the expected time of healing.[1] Over six million Canadians live with chronic pain. This costs the Canadian economy $6 billion per year in direct health care expenditures and an additional $37 billion per year in indirect productivity loss.[2] These shocking figures are comparable with those of cardiovascular disease, cancer, and diabetes.[3]

Why do we prescribe opioids in the first place for patients with chronic non–cancer pain? Recent evidence shows that the benefits of using opioid medications for chronic pain control may be outweighed by the negative consequences.[4] Yet, with the "pharmaceuticalization" of chronic pain management, there are strong pressures on physicians to prescribe opioids. Chronic pain is a complex, multifactorial condition that can be difficult to properly assess and treat during a typical time–constrained family doctor appointment. A well–meaning physician may therefore reach for their prescription pad even with the best of intentions. Unfortunately, physicians have few pharmaceuticals at their disposal for treating pain and patients often expect to be prescribed opioids.

In 2016, The College of Physicians and Surgeons of British Columbia (CPSBC) released Professional Standards & Guidelines to address opioid over–prescribing.[5] This included legal requirements that are enforceable under the Health Professions Act. There are now anecdotal reports in the media of patients instructed by their physician to reduce the dose of their opioid medication consequently causing the patient terrible suffering.[6-8] Some patients even reported turning to street drugs for pain relief. Physicians should be careful not to misinterpret the CPSBC guidelines. The guidelines are not commands and should be applied carefully on a patient–by–patient basis. When tapering opioids is appropriate, the dose should be reduced slowly and under close supervision by a physician in order to minimize withdrawal symptoms. Patients are likely to be fearful, and it is important to appreciate that pain–related fear beliefs can themselves increase pain.[9] We need to ensure patients with pain have well rounded pain management plans in place, particularly when tapering opioid medications.

Our reliance on opioids is indicative of a lack of alternative therapies.[10] In 2017, Doctors of BC released a policy statement to propose the development of a Provincial Chronic Pain Strategy, recognizing the urgent need to provide better access to alternative therapies.[11] Services such as physical therapy, intramuscular stimulation, mindfulness meditation, and cognitive behavioural therapy are known to help people with chronic pain but are less accessible than pharmaceuticals due to financial barriers. Medical cannabis is another alternative to opioids that is growing in popularity and deserves consideration by patients and physicians alike. Research has shown that cannabis has a relatively low risk of dependence and can both modulate pain signalling and improve psychological factors associated with pain.[12] Research has also shown that patients who have a better understanding of their pain have better outcomes.[13] Therefore, we should provide more pain education and empower patients to manage their own pain.

The gold standard of chronic pain management is multidisciplinary care that embraces the biopsychosocial model of pain.[10,14,15] This holistic approach integrates the roles of nutrition, movement, stress management, sleep, and mood in pain management. Unfortunately, access to multidisciplinary pain clinics is very limited in British Columbia. Wait lists for the few available specialized pain clinics currently range from one to three years.[7] This is particularly concerning, as patients with pain often deteriorate while waiting for access to care, and certain types of pain are more readily reversible when treated early.[16] Therefore, we should provide more funding to reduce wait times and improve access to multidisciplinary pain services in local communities.

Improving physician training is another key element of the long–term solution to Canada's pain and opioid crises. A 2009 survey of Canadian medical school curricula found that, on average, only 16 hours were spent on pain education over the entire multiyear duration

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of the program.[17] For comparison, the same study found veterinarians received an average of 87 hours of pain training. Based on these numbers it is not surprising that physicians are often not well equipped to help patients with pain. On a positive note, the Royal College of Physicians and Surgeons of Canada has launched a new two–year Pain Medicine sub–specialty residency program to provide more specialized pain training.[18] The University of British Columbia began accepting residents to the program in 2016. For now, physicians with less knowledge should collaborate with other physicians and healthcare professionals who have more experience in pain medicine. In the future, we should also expand pain education in medical school and residency of primary care physicians. This will ensure high quality care is accessible for all patients.[19]

There is also room for more research to increase our understanding of pain and its management. Fortunately, the University of British Columbia and Pain BC recognized this need and in April 2018 launched the BC Pain Research Network.[20] The network will bring together researchers of diverse backgrounds from across British Columbia with the aim to act as a catalyst for new pain research. The formation of this network is a key step forward for British Columbia. Health care providers, policy makers, and people with pain should all be open to engagement to ensure the research reflects the realties of pain.

Pain is undertreated in Canada, and patients with pain are at risk of being forgotten amidst the opioid crisis. We need to make sure patients with pain who are long–term opioid users are not harmed while well–meaning physicians reduce opioid prescribing. We also need to improve access to established non–pharmaceutical therapies, increase physician pain training, and conduct more research to develop new therapies to treat pain. Providing better and more comprehensive care may even lead to fewer opioid prescriptions and thereby play a role in the solution to the opioid crisis.

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